

PHYSICIAN INCENTIVE PLAN SUMMARY DATA FORM FOR PROVIDERS

Name of Provider: _____

Reporting year: _____

Note: Disclosure is required even if risk or substantial risk is not being transferred or panel exceeds 25,000.

CHECK ONE - Use this Summary Data Form to disclose the incentive arrangement between the first party (in the list below) that contracts with a second party (underlined on list below) for services to the MCO's Medicare (or Medicaid) enrollees. **Be sure to disclose subcontracting arrangements down to physician levels.**

-- Repeat forms as many times as needed to capture the various levels of contractual relationships.¹

-- For simplicity, "provider" is used here to refer to the second party. See instructions for completing this Form under "Single or aggregate disclosure" for aggregating either the first or second party.²

-- The HCFA Provider Data Worksheet can be the basis for this summary form. All forms and instructions are available at: www.hcfa.gov/medicare/physincp/pip-info.htm

(1) N/A MCO to physician group(2) N/A MCO to intermediate entity(3) N/A MCO to individual physician(4) _____ Intermediate entity to physician group(5) _____ Intermediate entity to physician(6) _____ Physician group to physician group(7) _____ Physician group to physician(8) _____ Physician to physician(9) _____ Intermediate entity to intermediate entity**1. The provider(s) named or counted should be the underlined provider in the line checked above.**

A. Name or Identifier of Provider: _____

Use actual name or any identifier for the provider or aggregated providers reported on this chart. If you are using an identifier for an aggregation of several entities, attach a list of names of the entities. Do not send lists of physician names unless requested by the managed care organization.

B. Number of Providers in the category selected: _____

Give # of providers who are aggregated on this form; e.g., if this form is for physician groups, category #4, then give the # of physician groups; groups can be aggregated if risk arrangements are substantially the same and stop loss requirements are the same.

1. C. Is provider a Federally Qualified Health Center or Rural Health Center? **Yes** _____; **No** _____
If providers are aggregated, see instructions for disclosing FQHCs.

1. D. If #7 above is selected, give number of physicians who are:

Members (e.g. owners, employees) of the group # _____; **Contracted with the group** # _____
These numbers must equal the number of physicians given in I.B.

NOTE: If #9 is checked above, this form is complete since stop loss requirements do not apply to intermediate entities (IE). However, be sure to complete disclosures for the IE's relationships with provider groups and their physicians (#4 and #7) and with individual physicians (#5) because stop loss requirements apply to these levels.

2. Is risk transferred to the provider? **Yes** _____; **No** _____

Note: A bonus for low utilization of referral services is considered to be risk transference.

If NO, this chart is finished. If YES, check all risk transfer methods with provider and go to question 3.

Capitation _____; **Bonus** _____; **Withhold** _____; **Percent of Premium** _____; **Other** _____

Note: Consider the obligation for the provider to fund deficits as a "withhold".

Describe briefly:

3. Is risk transferred for referrals? **Yes** _____; **No** _____
Note: A bonus for low utilization of hospital, specialist or other services is considered to be at risk for referral services.
If NO, this chart is finished. If YES, proceed to next question.

4. Check all the referral risk transfer methods with the provider and go to question 5.

Capitation _____; **Bonus** _____; **Withhold** _____; **Percent of Premium** _____; **Other** _____

Note: Consider the obligation for the provider to fund deficits as a "withhold".

If needed, describe briefly:

5. What percent of the total potential payment is at risk for referrals: _____%
If above 25% proceed to question 6; if 25% or below you have completed this disclosure.
6. Number of MCO patients served by the provider **or** the number of pooled patients, if patients can be pooled (see criteria for pooling in the instructions). Check one category:

A __ 1-1,000; **B** __ 1,001-5,000; **C** __ 5,001-8,000; **D** __ 8,001-10,000; **E** __ 10,001- 25,000; **F** __ 25,000+

If number is 25,000 or below, answer #7. If the number exceeds 25,000, you have completed this disclosure.

7. State the type and amount of stop loss insuring the physician group and/or physician:

Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and reimburses after the expected total cost exceeds a pre-determined level.

Individual insurance is where a specific provider excess loss accumulates based on per member per year claims.

Type: **Aggregate** _____; **Individual (per person)** _____; **Other** _____ (describe if aggregate or other)

If individual [based on costs per patient], enter threshold/deductible amount: [enter only one amount]

Threshold: **Professional** \$ _____; **Institutional** \$ _____; **Combined** \$ _____

Describe if needed:

I certify that the information reported in this disclosure is true, complete, and current to the best of my knowledge and belief and is made in good faith. I certify that the HCFA Physician Incentive Plan Worksheet has been completed in its entirety and will be retained on file in the event of a HCFA audit.

Signature: _____ Date: _____

CEO or Authorized Signatory of Physician Group/IE

Please Print/Type Name _____

SUBMIT THIS FORM TO THE MANAGED CARE ORGANIZATION

¹For example, if #6 (physician group to a subcontracted physician group) is checked on one form, then use a separate form and check #7 to disclose the subcontracted physician group's arrangement with its physicians.

²You must correctly represent the hierarchy of contracting and subcontracting relationships. For example, if you select # 6, you should aggregate all physician groups you contract with that have substantially the same incentive arrangements and stop-loss requirements. Then, on a separate form, you should select #7 to enter the physician group-physician arrangements only for the physicians associated with those provider groups. These related disclosures should be stapled together.